

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047917

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 6542

STATE FILE NUMBER

FILED DEC 19 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>87 yrs</b>		Inside Limits <b>Yes</b> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3668 Madison</b>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Barbara</b> Last <b>Bessenbacher</b>		4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1872</b>
9. AGE (last birthday) <b>91</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (City and state or country) <b>Peoria, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John Bessenbacher</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret (no record)</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs. Margaret Willer</b>		Address <b>K.C., Mo.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Margaret Willer</b>		Address <b>K.C., Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malignant hypertension</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <b>9:30</b> a.m. <b>PM</b> Month, Day, Year <b>Oct 11, 63</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>1103 Grand Avenue</b>	
20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		COUNTY <b>Missouri</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>Oct 11, 63</b> to <b>Dec 2, 63</b> and last saw her alive on <b>Dec 2, 63</b> . Death occurred at <b>9:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Typed or title) <b>John B. Willits M.D.</b>		22b. ADDRESS <b>1103 Grand Avenue</b>	
22c. DATE SIGNED <b>12/4/63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>12/5/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
23d. LOCATION (City, town, or county) <b>Kansas City</b>		(State) <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Wagner Funeral Home</b>		ADDRESS <b>K.C., Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>12-4-63</b>		26. REGISTRAR'S SIGNATURE <b>Beasie Smith</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

John B. Willits MEDICAL CERTIFICATION

710720-004

11:11:30 AM  
Type B  
Drog Body

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed David R. Harnischfeld

Licensed Embalmer No. 4159  
P. O. Address P. E. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

-If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.